

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12815

FILED MAR 20 1953

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 758

1. PLACE OF DEATH  
a. COUNTY ST. LOUIS COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death)  
a. STATE FLORIDA b. COUNTY HERNANDO

3. NAME OF DECEASED  
a. (First) IDA b. (Middle) HAYES c. (Last) HAYES

4. DATE OF DEATH (Month) (Day) (Year)  
MARCH 7, 1953

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED WIDOWED 8. DATE OF BIRTH (Month) (Day) (Year)  
JULY 21, 1869 9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY HOME 11. BIRTHPLACE (City and State or Foreign Country) LOUISIANA, MISSOURI 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME JOHN SCHMITT 13b. MOTHER'S MAIDEN NAME MINA SCHMITT 14. NAME OF HUSBAND OR WIFE Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. NONE 17. INFORMANT'S SIGNATURE OR NAME John F. Schmitt Louisiana ADDRESS Mo.

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)  
\*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) CHRONIC MYOCARDITIS

ANTECEDENT CAUSES  
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) ARTERIO SCLEROSIS  
DUE TO (c) SENILITY

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death. NONE

19a. DATE OF OPERATION 4221 19b. MAJOR FINDINGS OF OPERATION 4221 20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) — 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) — 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21f. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from JAN. 5, 1952, to MAR. 7, 1953, that I last saw the deceased alive on MAR. 6, 1953, and that death occurred at 7:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) B. R. Loving, M.D. 23b. ADDRESS BALLWIN, MO. 23c. DATE SIGNED 3-7-53

24a. BURIAL CREMA- TION BURIAL 24b. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEM. 24c. LOCATION (City, town, or county) (State) LOUISIANA, MO.

DATE REC'D BY LOCAL REG. MARCH 9 1953 REGISTRAR'S SIGNATURE Herbert R. Danks, M.D. 25. GENERAL DIRECTOR'S SIGNATURE Geo. M. Collier ADDRESS Mortuary Louisiana, Mo.

P.L. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 9 1956

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Geo. M. Callier*

Licensed Embalmer No. *3839*

P. O. Address *Louisiana, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.